

Group Purchasing Alliances For Small Employers



Report to Joint Committee on Health Care Oversight
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REPORT TO THE LEGISLATURE ON A PURCHASING ALLIANCE FOR SMALL EMPLOYERS

Executive Summary

Purchasing alliances frequently are suggested as a mechanism for making health insurance more affordable for small employers. The Rhode Island legislature, in a joint resolution passed in the spring of 2004, directed the Health Insurance Commissioner to produce “an evaluation of a purchasing alliance for the smallest of businesses that have experienced the most severe premium increases.” This report examines the experience to date with such purchasing arrangements.

The terms purchasing alliance, purchasing cooperative and purchasing pool are generally interchangeable. All describe an entity that, in theory:

- Exercises combined purchasing clout and professional expertise in purchasing health insurance on behalf of a group of employers;
- Gives employees a choice of competing health plans that offer standardized benefit packages, facilitating comparison across plans; and,
- Reduces costs by consolidating administration on behalf of multiple small employers and health plans, thereby reducing overhead costs.

In practice, success with purchasing pools has been very limited. Studies of the impact of purchasing pools have found that the pools have not reduced premiums for small businesses, relative to rates outside the pools, and they have not increased the likelihood that small businesses will offer insurance to their employees (Long and Marquis; Wicks et al; Kahn and Pollack, 2001). An analysis of data from the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey found that purchasing pools did increase modestly the availability of choice and information for employees, but did not necessarily increase coverage rates among employers or reduce employer coverage costs (Long and Marquis). Another study of six major small-group purchasing cooperatives nationwide found that “The continuing appeal of pooled purchasing and its apparent advantages for small employers and their workers stands in stark contrast with the very modest success of the concept in practice.” (Wicks et al).

Nonetheless, some examples of functioning purchasing pools do exist. A number of states have passed legislation that either authorizes or requires the creation of “purchasing alliances” or “purchasing cooperatives.” There also have been some private-sector initiatives aimed at the same purpose. At this point, however, fewer than 20 purchasing pools exist in the country and their total enrollees number fewer than a million (Wicks et al, 2000). In general, these initiatives have not been very successful, but there are some notable exceptions.

This report concludes that, while there is a clear public interest in making health insurance more affordable for small employers, it is unlikely a purchasing pool would

accomplish this objective in Rhode Island. Group purchasing arrangements are unlikely to provide significant relief from the cost pressures faced by small employers, and other policy actions, either at the state or federal level, will likely be necessary to address this problem.

Introduction and background

Purchasing alliances frequently are suggested as a mechanism for making health insurance more affordable for small employers. The Rhode Island legislature, in a joint resolution passed in the spring of 2004, directed the Health Insurance Commissioner to produce “an evaluation of a purchasing alliance for the smallest of businesses that have experienced the most severe premium increases.”

A purchasing alliance, sometimes called a healthplan purchasing cooperative (HPC) or a purchasing pool (the term we will use here) is an entity that arranges coordinated purchasing of health insurance by small employer groups. Small employers often have difficulty finding affordable health insurance for their employees. Sometimes this is because the employee group includes one or more people who have significant health problems, and the employee group is not large enough to absorb the costs. In addition, the administrative costs incurred by insurers in selling to smaller groups are generally high (relative to larger groups), and contribute to higher premiums. Small employers also

lack leverage in the buying process with insurers. They do not bring enough volume of business to insurers to command lower prices.

Moreover, small employers often lack the administrative capacity and expertise necessary to offer employees a choice among insurance plans. Choice is often a feature in large employer coverage, and is believed to encourage efforts on the part of health plans to improve services and quality (Zelman, 1994).

What is a purchasing pool?

Multiple employer purchasing arrangements are not a new concept. Pooled purchasing arrangements, defined broadly, are utilized by a significant proportion of small employers. One study found that 33 percent of firms with fewer than ten workers and 28 percent of firms with ten to 49 workers participate in pooled purchasing, if the term is defined very broadly to include purchasing cooperatives, multiple-employer trusts, multiple-employer welfare associations, and trade professional or other membership organizations (Long and Marquis, 1999).

However, participation in some kinds of employer purchasing arrangements depends on membership in a specific group, such as a trade association. Participation also might be subject to a group's health status – if an employer group includes some people who are likely to have significant health care expenditures, the group might not be admitted, or might be charged a much higher premium for participation. This kind of association

health plan is voluntary, meaning all members of the association are not required to participate. The association enrolls members groups in health plans and receives a fee from the health plan for performing this function. Rules about how these employer purchasing arrangements can operate vary from state-to-state. In Rhode Island, most of these arrangements were prohibited by the adjusted community rating law passed in 2000.

In the 1980s a new concept of pooled employer purchasing began to emerge. As large employers began to take a more active role in bargaining for health insurance in order to hold down costs, policy analysts began exploring the possibility of creating the same leverage for small employers through pooling. Couldn't small employers band together, the thinking went, and exert the same sort of pressure on the market? The idea was championed by some notable health policy experts, including the Jackson Hole Group, as part of a system of "managed competition" (Zelman). One version of this concept was included in President Clinton's health reform proposal in 1993, where the purchasing arrangements were referred to "alliances." The key distinctions between this version of multiple-employer purchasing and those that existed previously were:

1. *Participation was mandatory.* Employers would be required to provide insurance to employees, they would have to do so through a regional purchasing pool, and they would be required to pay a portion of the premium. This would guarantee the pools a certain volume of business, which would attract interest from health

plans and create pressure on the health plans to negotiate lower prices with the purchasing pools.

2. *The small group insurance market was reformed.* Certain reforms would be made to the small group insurance market, which would “level the playing field” for all small employers by reducing the rate differentials between groups and by assuring that groups had access to insurance regardless of their risk status. Many states, but not all, have enacted such reforms in the past fifteen years, and some reforms were included in the Health Insurance Portability and Accountability Act (HIPAA), passed by Congress in 1996.
3. *The purchasing pools were permitted to negotiate with health plans.* The purchasing pools would be large blocks of business, and pool managers would bargain for lower premiums based on their volume and cost control efforts undertaken (but not based on the health risk profile of the alliance members).
4. *Subsidies were provided.* Subsidies would be provided by the government, through the purchasing pools, to both low-income individuals and needy small businesses.
5. *Standardized plans were required.* The purchasing pools would offer a choice between standardized benefit plans, offered by competing health plans, facilitating “apples-to-apples” comparisons between plans by employees.
6. *Managed care was required.* The purchasing pools would offer managed care options among the choice of plans, encouraging consumers to choose these plans, which were presumed to be lower cost and higher quality. The purchasing pools

were envisioned not only as a means of controlling costs but also as a means of encouraging more employees to choose a managed care option.

Despite the enthusiasm for this model in the mid-90s, the performance of actual purchasing pools has been mostly disappointing. This is due in large part to the fact that many of the conditions assumed necessary for the managed competition type of purchasing pool have not materialized. Most notably, employers are not required to offer or pay for health insurance for their employees, and subsidies are not available to most employed individuals to pay for insurance. In addition, insurance reform has not been uniform nationally, and in some states existing regulations undermine the success of purchasing pools.

Nonetheless, some examples of functioning purchasing pools do exist. A number of states have passed legislation that either authorizes or requires the creation of “purchasing alliances” or “purchasing cooperatives.” There also have been some private-sector initiatives aimed at the same purpose. At this point, fewer than 20 of this newer type of purchasing pool exist in the country and their total enrollees number fewer than a million (Wicks et al, 2000). The most prominent examples have been in California, Florida (though the Florida alliances closed in 2000), Connecticut, Texas and Colorado. In general, these initiatives have not been very successful, but there are some notable exceptions.

The rules of participation in purchasing pools, the rating rules within the pools and the markets and insurance regulations within which they operate vary considerably.

Nonetheless, some core characteristics are common to them¹. These characteristics are:

- they exercise combined purchasing clout and professional expertise on behalf of employers who voluntarily enroll their employees in the pool;
- they give employees a choice of competing health plans that offer standardized benefit packages, facilitating comparison; and,
- they achieve savings by consolidating administration on behalf of multiple small employers and health plans, thereby reducing overhead costs.

Pools perform a number of functions for their members, all aimed at reducing insurance costs, simplifying administrative processes and increasing the health insurance options and the quality of those options available to enrollees. The basic functions of a purchasing pool are:

- *Contracting with health plans.* Purchasing pools contract with health plans to potentially provide coverage to enrollees within a defined region. The original concept was that purchasing pools would be selective in contracting, choosing only those plans deemed to be the best in their region. In practice, pools have had trouble attracting participation from carriers.

¹ Much of the descriptive information in the following section is drawn from the web site of the Institute for Health Policy Solutions (www.ihps.org) and from their “Resource Manual for Implementing Healthplan Purchasing Cooperatives,” 1995, IHPS.

- *Enrolling employees in health plans.* The purchasing pool centralizes and standardizes the enrollment process, thereby reducing costs and making the process simpler for employers and employees. Some purchasing pools have used a third-party administrator for this function.
- *Collecting and distributing premiums.* Employers send a single premium check to the purchasing pool and the pool distributes funds to the health plans according to their enrollment. In some cases purchasing pools also have administered a risk-adjustment system, whereby they adjust the amount of premium paid to plans to reflect the relative health of the population enrolled in each plan.
- *Collecting, analyzing and publishing information on plan characteristics and performance.* Purchasing pools help consumers distinguish between plans based on cost and quality by providing information to enrollees on some regular (usually annual) basis. The information provided usually includes employee satisfaction ratings for various plans and/or plan performance measures such as the Health Employer Data and Information Set (HEDIS).

Experience with purchasing pools

In general, success with purchasing pools has been very limited. Studies of the impact of purchasing pools have found that the pools have not reduced premiums for small businesses, relative to rates outside the pools, and they have not increased the likelihood that small businesses will offer insurance to their employees (Long and Marquis; Wicks et al; Kahn and Pollack, 2001). An analysis of data from the 1997 Robert Wood Johnson

Foundation Employer Health Insurance Survey found that purchasing pools did increase modestly the availability of choice and information for employees, but did not necessarily increase coverage rates among employers or reduce employer coverage costs (Long and Marquis). Another study of six major small-group purchasing cooperatives nationwide found that “The continuing appeal of pooled purchasing and its apparent advantages for small employers and their workers stands in stark contrast with the very modest success of the concept in practice.” (Wicks et al).

Unfortunately, the success of purchasing pools depends most fundamentally on attracting a critical mass of employers to the pool and maintaining their participation. But building market share has been a challenge for all but a few pools, and particularly for state-sponsored pools. Purchasing pool market share has generally been below 5 percent (ibid). As one study reports:

“The fundamental problem is market share: health purchasing cooperatives (HPCs) cannot attract and retain prestigious health plans, achieve significant economies of scale, and negotiate lower premiums without market share. Yet HPCs cannot achieve large market share without attracting and retaining the best insurers, offering lower premiums and achieving economies of scale.” (ibid, p.5)

Purchasing pools, in theory, offer three advantages:

1. they create economies of scale that reduce the administrative costs associated with offering insurance;

2. they allow small employers to realize some of the bargaining clout enjoyed by large employers; and
3. they allow employees of small firms a choice of plans and premiums, an option that small employers often also lack the capacity to offer.

In practice, pools have had little impact on cost (and thus on employer and employee access to coverage), and can really only claim success in terms of enhancing employee choice.

Why have purchasing pools had such difficulty?

A number of factors have been cited in explaining why purchasing pools have not, in general, been more successful in attracting market share. Each pool has faced a somewhat unique combination of challenges, as the mix of the rules of the game and the operating environment for pools varies from location to location. However, some of the common pitfalls are discussed below.

Pool instability

Because purchasing pools have had trouble maintaining a large and stable population, insurers have had trouble underwriting the pools in a reliable manner. In the absence of good retrospective data on the claims experience of a pool's population, health plans are forced to predict likely health care use, and are more likely to charge higher prices to

“hedge their bets” with higher rates, or to change rates based on experience from year-to-year, resulting in rate volatility for pool members. This is exacerbated by the fact that insurers are not able to count on getting the pool’s entire book of business in a given year. Employee choice might make pools attractive for employees, but choice can make pools unattractive for insurers who might end up insuring only the worst risks from within a group of employees.

Lack of price competition

As one analysis of purchasing pools concludes, “The lack of a price advantage to purchasing within most alliances is cited as a critical factor accounting for their low market penetration.” (Kahn and Pollack, p. 41). Simply put, the savings expected from pooled small employer purchasing has not materialized. This may be due in part to changes in the environment. Small group insurance premiums inflated less rapidly in the years just after the creation of most purchasing alliances (the late 90s) than they had in the early 90s. This may have made it more difficult to attract small employers to a new way of purchasing insurance. In addition, the level of competition has increased in the small group market generally (Wicks et al), resulting in some cost reductions and less “fat” to be trimmed.

Some purchasing pools were seriously restricted in terms of their negotiating power by the statutes that created them. For example, a substantial number of purchasing pools, unlike large employers, were prevented by law from negotiating prices with health plans

except for the portion of the premium attributable to administrative cost. This was the case in Florida, where regional purchasing pools ultimately failed.

Lack of health plan participation

Health plans have been lukewarm at best toward purchasing pools, with the exception of some pools that are run by business groups. While the concept of pooling small employers to yield greater clout had much appeal for states and employers, health plans had little interest in creating large purchasing groups to bargain against them.

In addition, plans had some apprehension about state-run or state-created purchasing cooperatives replacing private market purchasers and becoming price “setters” (as Medicaid and Medicare are sometimes characterized), who might not bargain fairly.

In addition, some health plans did not like the idea of standardizing their products to purchasing pool specifications, rather than selling their own pre-existing products. Plans also expressed concerns about adverse risk selection in purchasing pools, particularly in states where the pool was not permitted to use medical underwriting, while such underwriting was allowed in the general market. This was a concern both in terms of the overall risk profile of the pool and in terms of the employee choice provision – plans could not count on attracting an entire employer group, and feared they would end up with only the unhealthy employees.

Lastly, plans have said that they were reluctant to cede control to purchasing pools over some of the core functions of their business, such as premium collection and enrollment, where accuracy and timeliness was paramount.

Opposition from agents and plans

While some health plans were apprehensive about purchasing pools, others were outright hostile. This was even more frequently the case with insurance agents, who, in most cases, got cut out of the transaction when small employers chose to join purchasing pools. As one group of experts observes, “The primary reason existing purchasing pools do not have a larger share of the small group market is resistance from health plans and agents. Health plan participation is crucial because, without it, pools have no product to offer. Support from agents also is critical because they are small employers’ primary source of information on insurance matters.” (Curtis et al, 2000)

Several of the more successful purchasing pools (California, Cleveland, Colorado and New York, for example) have been either initiated by a business group or administered by a business group. This arrangement seems to have raised less opposition from health plans, and may have provided expertise that was not available to government-run pools. However, two cautions are worth noting:

1. The successful pools have been heavily reliant on a large anchor account.

Without this critical block of business, the pools would not be successful.

2. While health plans may be more trusting of business-run purchasing pools, the state as insurance regulator takes on an increased role in terms of policing these arrangements to assure that they are not operating in such a manner as to disadvantage other purchasers in the market.

Lack of marketing

Most purchasing pools were given limited budgets for marketing to small employers and employees. Pool administrators have learned, over time, that you can't "just build it and they will come." Active and effective marketing is necessary to convince employers to shift their business to a purchasing pool.

Positive effects of purchasing pools

While purchasing pools have not been particularly effective at attracting market share and thus lowering premiums for employers, they have produced some positive results for employers. These are summarized below.

Choice of plans

While they have not been successful in garnering market share, and thus reducing prices, purchasing pools "clearly have been successful in offering a new product that meets a need for small employers – a choice of several health plans and/or benefit levels with the

requirement, or at least an option, that individual employees can choose among all the plans offered” (Wicks et al). This feature has been acknowledged widely as being the most important in attracting small employers to purchasing pools. Offering a choice of plans outside of the pool simply is not practical for many small employers. Purchasing pools also have allowed some small employers to offer managed care without forcing all of their employees into a managed care option. However, pools generally have had trouble offering PPO options to employers due to health plan concerns that PPOs would attract unfavorable risk.

Competition

Prices in purchasing pools generally are not lower than those found in the outside market, but they generally are not higher, either (Kahn and Pollack; Wicks et al; Long and Marquis). However, there is some geographic variation in the effect of purchasing pools on rates, with members of the California pool realizing some clear rate advantages while pool members in other states pay rates comparable to the general market (Kahn and Pollack). In spite of the fact that purchasing pools have, in most locales, fallen short of expectations for reducing costs, there is some evidence of that the presence of pools in the market has spurred competition among health plans, particularly in terms of the design of products offered and the availability of a choice among plans. In some states, health plans even have developed options for individual employee choice outside of purchasing pools, essentially mimicking the pools (Wicks et al).

Conclusion

Small employer groups are at a disadvantage in the health insurance marketplace. They face higher prices than large employer groups, and employees of small firm are much less likely to be offered health insurance, than are employees of large firms. In addition, employees of small firms are far less likely to be offered a choice of health insurance plans than are employees of larger firms (AHRQ, 2003).

There is a public interest in “leveling the playing field” for small employers so that they are able to obtain health insurance at competitive prices. However, it is not clear that a purchasing pool would accomplish this objective in Rhode Island. Purchasing pools are an attractive concept in that they do not involve much intervention from government and they allow small employers (in theory) to harness the market power available to large employers. However, actual experience with purchasing pools has been disappointing. Most voluntary purchasing pools (that is, those for which participation is not mandated by law) have not been effective. They have not attracted a critical mass of employer groups and have not been able to command lower prices than employers face in the open market. Other, self-insured forms of group purchasing, such as association health plans and MEWAs, have faced even greater challenges of both risk and fraud

The bottom line is that group purchasing arrangements are unlikely to provide significant relief from the cost pressures faced by small employers, and other policy actions, either at the state or federal level, will likely be necessary to address this problem.

References

Agency for Health Care Research and Quality, Center for Financing, Access and Cost Trends. 2003 Medical Expenditure Panel Survey – Insurance Component.

www.meps.ahrq.gov.

Curtis, Richard E., Edward Neuschler and Rafe Forland. “Private Purchasing Pools to Harness Individual Tax Credits for Consumers.” A report from the Commonwealth Fund Task Force on the Future of Health Insurance. www.cmwf.org. December, 2000.

Curtis, Richard E., Edward Neuschler and Rafe Forland. “Consumer-Choice Purchasing Pools: Past Tense, Future Perfect?” Health Affairs, 20(1): 164-168. January/February 2001.

Institute for Health Policy Solutions and Academy of Healthplan Purchasing Cooperatives. “Implementing Healthplan Purchasing Cooperatives: A Resource Manual.” Washington, DC, 1995.

Kahn, Charles N. III and Ronald F. Pollack. “Have Small Group Health Insurance Purchasing Alliances Increased Coverage?” Health Affairs, 20(1): 40-48. 2001.

Long, Stephen H. and Susan Marquis. Pooled Purchasing: Who are the Players?” Health Affairs, 18(4): 105-111. July/August 1999.

Wicks, Eliot K, Mark A. Hall and Jack A. Meyer. "Barriers to Small Group Purchasing Cooperatives. Report of the Economic and Social Research Institute. March, 2000.

Zelman, Walter A. "The Rationale Behind the Clinton Health Care Reform Plan" Health Affairs, Spring, 1994: 9-29.

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